# Health Safety Net
# Implementation and Eligibility

## A Report by the Executive Office of Health and Human Services
## Division of Health Care Finance and Policy
## &
## Office of Medicaid

*Submitted in compliance with Chapter 61 of the Acts of 2007*

## March 13, 2009


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# Table of Contents

# Section I: Executive Summary

The Division of Health Care Finance and Policy (the Division) and the Office of Medicaid (MassHealth) are submitting this joint report to the Massachusetts legislature in compliance with Sections 45 and 15 of Chapter 61 of the Acts of 2007.

Section 45 requires these agencies to "develop and implement a plan to achieve improvements in the operations, management, payment processes and data integrity of the health safety net..." Section 45 specifically requires the improvement plan to develop processes to target audits, to identify sources of third party liability, to implement an ongoing utilization review program, and to maximize the use of MassHealth's existing systems for eligibility determination and review, claims review, and provider integrity.

This report summarizes the activities undertaken by the Health Safety Net Office (HSNO), a unit within the Division, and MassHealth to jointly implement management improvements in the administration of the Health Safety Net (HSN). The Division and MassHealth have developed a coordinated eligibility process by means of the MassHealth MA-21 eligibility determination system and the Executive Office of Health and Human Services' Virtual Gateway eligibility portal. The agencies have continued to develop enhanced, coordinated eligibility systems in order to provide a seamless, single point of entry for applicants seeking access to MassHealth, Commonwealth Care, and the HSN.

The Division also worked closely with MassHealth in developing the new claims-based payment system required by Chapter 58 of the Acts of 2006, the health care reform law. During HSN fiscal year 2008 (HSN08), the Division implemented a defined scope of HSN covered services based on the MassHealth Standard benefit package, ensuring that the HSN leverages MassHealth's expertise and ensures consistency with existing clinical policy decisions. In addition, all prescription claims for HSN patients are processed through the MassHealth Pharmacy Online Payment System (POPS), providing a coordinated approach to coverage, prior authorization, payment, and post-payment review. The agencies' activities with respect to implementing the revised claims processing payment system are detailed in this report.

The report outlines the coordination of activities to monitor payments and claims trends. These activities permit the Division to verify appropriate billing practices and to take corrective actions as necessary. In addition, the agencies are coordinating implementation of a third-party liability identification program designed to recover funds such as accident recoveries on behalf of the HSN and to ensure that the HSN is the payer of last resort. This report also describes the Division's contracts with vendors to conduct post-payment clinical utilization review of claims, to verify medical necessity and appropriate clinical billing practices, and to perform compliance audits of providers to monitor and verify appropriate reporting to the Division. The report provides a work plan of the current and planned activities for the operation and management of the HSN.

Section 15 of Chapter 61 requires the Division and MassHealth to annually report on an evaluation of the processes used to determine eligibility for reimbursable health services. Specifically, Section 15 calls for an analysis of the effectiveness of these processes in enforcing eligibility requirements, an assessment of the impact of these processes on the level of HSN services, and recommendations for ongoing improvements to enhance eligibility determination systems. This report addresses this evaluation and illustrates that service utilization has declined since the implementation of the HSN. Through continued coordination and collaboration between the Division and MassHealth, the agencies will continue to achieve improvements in the operation and administration of the HSN.

# Section II: Health Safety Net Overview

## A. Background and Financing

The Health Safety Net (HSN) was created by Chapter 58 of the Acts of 2006, the health care reform law, as the successor to the Uncompensated Care Pool (UCP). The HSN, like its predecessor, is designed to serve as a safety net for uninsured and underinsured residents by reimbursing acute care hospitals and community health centers (CHCs) for allowable services provided to this population.

The HSN is funded through three primary sources: an assessment on hospitals, an assessment on insurers, and a state appropriation. In HSN fiscal year 2008 (HSN08), funding from these sources totaled approximately $370 million. In addition, the Division made $24 million available to the HSN from prior years' residual UCP funds and funding of $60 million from the Medical Assistance Trust Fund. As health care reform progresses and more residents obtain coverage, it is expected that HSN service utilization and the amount of funding required for the HSN will continue to decline.

Chapter 58 made two major changes to the method of paying providers for HSN services. Prior to HSN08, hospital payments were made using a block grant system in which rate year payments were based on prior year hospital charges reported to the UCP. As mandated by Chapter 58, the HSN pays hospitals based on adjudicated claims after verifying that the patient is eligible and the services are covered.

Following are the key dimensions of the HSN payment rates as implemented by the Division:

- Inpatient services are paid using hospital-specific rates adjusted for variations in patient acuity, teaching status, and percent of low-income patients.
- Outpatient services are paid using a per-visit rate developed by estimating the amount Medicare would have paid for comparable services. Additional outpatient adjustments are made for disproportionate share and community hospitals.
- CHCs are paid by the HSN using the federally qualified health center (FQHC) medical visit rate. Ancillary services provided by CHCs are paid at MassHealth payment rates including all applicable rate enhancements.
- Outpatient prescription drugs for eligible hospitals are paid using the pharmacy online payment system (POPS) used by the MassHealth program. Pharmacy claims are priced using the MassHealth fee schedule.
- Distinct rates were set for emergency room bad debt (ERBD) services provided by hospitals.

## B. Policy and Management Strategies

In determining policies and management strategies, the Division sought to ensure that the HSN supports the overall objectives of health care reform. To that end, the eligibility requirements, covered services, patient cost sharing, and payment methods have been coordinated with MassHealth and the Commonwealth Health Insurance Connector Authority. In addition, the Division consulted with the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers and other key stakeholders, such as individual hospitals, CHCs, and patient advocates, in developing and implementing the HSN eligibility and payment policies and regulations.

# Section III: Health Safety Net Implementation

## A. Joint Plan for Improvement in HSN Operations

There are several key areas in which the Office of Medicaid provides direct operational support towards the administration of the HSN, in particular:

- *Eligibility Determinations*. MassHealth, through the MA-21 system, administers the central processing functions to determine eligibility for health care coverage for state health care programs, including MassHealth, Commonwealth Care, and the HSN. This centralized process allows Massachusetts residents to apply for coverage using a common application at the point of service. While this centralized process has been in place for several years between MassHealth and the UCP, health care reform has greatly increased the critical role of this system.
- *Covered Services*. In HSN08, the Division adopted the MassHealth Standard benefit package as the package of services covered under the HSN. MassHealth Standard is the most extensive of any MassHealth benefit program, resulting in a comprehensive scope of services allowable under the HSN. Only MassHealth Standard services that can be provided in a hospital or a CHC setting are covered by the HSN. This policy coordination leverages the existing clinical decision-making and resources used by MassHealth.
- *HSN Secondary*. With the transition to the HSN, secondary payment rules were modified; now HSN pays only for services not covered by MassHealth non-comprehensive benefit programs such as MassHealth Limited.
- *Provider Communication*. MassHealth also administers the systems that inform providers of patient eligibility in MassHealth, Commonwealth Care, and the HSN. The Division and MassHealth have coordinated to improve the messages that providers receive regarding HSN patient eligibility through the Recipient Eligibility Verification System (REVS). Both agencies are currently collaborating to ensure continued quality of provider messaging after the transition to NewMMIS, which will replace both MMIS and REVS and become the claims processing system for MassHealth.
- *Pharmacy Payment*. MassHealth, through the Pharmacy Online Payment System (POPS), administers the claims administration and utilization review program for all outpatient prescriptions provided to HSN patients by CHCs and hospitals. In addition, the HSN and MassHealth use a common fee schedule when making payments to hospitals and CHCs for these services.

The Division and MassHealth have coordinated on a number of key operational functions in administering the HSN. In particular, several groups made up of key personnel from the Division and MassHealth meet regularly to coordinate resources, review outstanding operational issues and coordinate information technology issues. Additionally, teams meet monthly to coordinate various health care reform initiatives among the Division, MassHealth, and the Commonwealth Health Insurance Connector Authority. The Director of the Health Safety Net Office also sits on the NewMMIS steering committee in order to coordinate efforts between the Division and MassHealth in the development of the NewMMIS. The Division and MassHealth have also initiated Interdepartmental Service Agency Agreements to address the specific requirements of section 45 of Chapter 61 of the Acts of 2007.

## B. Patient Eligibility System

The Health Safety Net Trust Fund serves as a payer of last resort for patients who are unable to obtain affordable health coverage through other sources. To that end, patients are first screened to determine

eligibility for affordable insurance coverage. In addition, the HSN does not make payments to providers if another payment source is available. To ensure compliance with these principles, the Division:

- Maintains coordinated eligibility policies that provide appropriate incentives for patients to enroll in affordable and comprehensive insurance plans;
- Utilizes a common application and maintains the MA-21 system to ensure that eligibility policies are coordinated and applied consistently;
- Performs reviews to ensure that all other payer sources have been exhausted when payment is made from the HSN; and
- Leverages existing contracts and resources to minimize duplication of effort and promote consistent policies.

## Implementation Activities

***Coordinated Eligibility Policies***. As part of the transition from the UCP to the HSN, the Division substantially revised eligibility policies. These policies were implemented in HSN08, and preclude HSN coverage for services if the patient is eligible for insurance coverage through an alternative source such as MassHealth, Commonwealth Care, or through an employer.

Some of the key eligibility policies include:

- Patients are eligible for the HSN if they are uninsured and document family income between 0% and 200% of the federal poverty level (FPL).
- Patients eligible for MassHealth comprehensive benefit programs, such as MassHealth Standard, Basic or Essential, are not eligible for the HSN.
- The HSN provides eligibility to patients in "gap" periods; that is, for 10 days prior to a patient's application for certain MassHealth programs or for Commonwealth Care, and up to 90 days after the application in order to allow sufficient time for an individual to complete the enrollment process.
- The HSN covers the same range of services that are covered under MassHealth Standard as provided by an acute hospital or CHC.
- Patients between 201% and 400% of the FPL are eligible for partial HSN coverage, which includes a deductible based on the patient's income.

***Pre-Payment Eligibility***. MassHealth, through the MA-21 system, is responsible for reviewing Medical Benefit Request (MBR) applications for eligibility for state-funded insurance programs such as MassHealth and Commonwealth Care, and the HSN. The pre-payment eligibility tool in place, the Virtual Gateway, assists consumers with submission of a common MBR application. The Office of Medicaid initiates data matches with other agencies and information sources when a MassHealth application is received in order to verify income and determine program eligibility. These agencies and information sources may include, but are not limited to, the HSN, the Commonwealth Health Insurance Connector Authority, the Department of Unemployment Assistance, the Department of Revenue, and other state and federal agencies.

***Recipient Eligibility Verification System (REVS)***. When patients seek care at hospitals and CHCs, providers determine the patient's eligibility at time of registration by accessing REVS. The Division and MassHealth have collaborated to identify and implement patient classification changes to support the implementation of HSN eligibility and patient cost sharing policies. These changes allow providers to better understand whether an individual is eligible for, but not yet enrolled in, MassHealth or Commonwealth Care and whether the individual's care may be charged to the HSN.

***Customer Service***. The Division contracted with Public Sector Partners of the University of Massachusetts (UMass) to provide customer service support to HSN patients and providers. The Division, the Office of Medicaid, and the Commonwealth Health Insurance Connector Authority are also coordinating call center support among the HSN, MassHealth, and Commonwealth Care programs in order to provide coordinated customer services, consistent messaging, and appropriate call transfers as necessary.

***Provider Outreach and Support***. The Division and MassHealth staffs convene joint training sessions to reach out to hospital and CHC staffs on the policy and patient eligibility processes and operations. The agencies leverage the existing MassHealth Training Forum and MassHealth provider publications to inform providers and patient advocates of key HSN operational issues.

## C. Claims Processing System

In order to ensure that payments are made to providers for appropriate reimbursable health services, the Division implemented the following practices:

- A claims adjudication system that screens out ineligible services and pays providers appropriately.
- A claims reporting system that provides the Commonwealth and providers with the appropriate level of information needed to ensure appropriate payment.
- A utilization review program to verify that hospitals and CHCs conform to HSN rules regarding covered services and site of service.

### Implementation Activities

***HSN Claims Adjudication.*** Chapter 58 of the Acts of 2006 requires that payments made from the HSN are based on Medicare payment principles. Historically, payments from the UCP were made on a prospective, cost-based system. To implement this change, the Division instituted an in-house claims processing system for HSN medical claims. This system prices claims according to the appropriate payment method, paying only for covered services delivered to eligible individuals. In addition, the Division partners with providers to transition to a HIPAA compliant claims submission format, the "837," which is considered the industry standard. The 837 claims format captures the level of information needed to efficiently price hospital claims in accordance with the Medicare payment models.

Ninety-eight percent of all HSN hospital providers now submit claims in the 837I format. CHCs are in the process of transitioning to submitting claims in the 837P and 837D formats. As of February 1, 2009, 40% of CHCs passed 837P claims edit testing thresholds and they continue to work with the Division to establish a go-live date.

***Pharmacy Claims***. Through an interagency service agreement (ISA) between the Division and EOHHS, pharmacy claims are processed and priced using the MassHealth Pharmacy Online Payment System (POPS), leveraging the MassHealth pharmaceutical management program and its pharmacy payment rates for the HSN. In addition to a common set of pricing algorithms, the ISA allows the Division to use the prior authorization policies and the MassHealth preferred drug list for prescription drug claims. Under this agreement, EOHHS and POPS will process the pharmacy claims and provide the Division with claim information to make payments, generate remittance reports, and manage HSN prescription drugs.

An ISA is currently in effect between the Division and University of Massachusetts Medical School (UMMS) to provide pharmacy management and drug utilization reviews for the HSN. As part of this ISA, UMMS:

- Oversees the medical necessity determinations of prior authorization requests for prescription drugs, in accordance with HSN policy and clinical guidelines approved by the Division;
- Serves as clinical consultant to the HSN Drug Utilization Review Program;
- Makes recommendations to the Division regarding pharmacy forecasting and cost savings in the pharmacy program; and
- Manages the clinical and administrative aspects of the POPS vendor contract with respect to HSN pharmacy benefits.

## D. Program Integrity Initiatives

The Division is implementing several program integrity initiatives to ensure the effective administration of the HSN. To achieve this objective, the Division will complete the following activities:

- Continue routine monitoring, analyses and reporting to track HSN eligibility and service utilization, identify potential problem areas, understand underlying causes, and, when indicated, develop the appropriate action plans;
- Implement approaches and systems to strategically address third party liability cases where another payer could be responsible for payment;
- Implement screening and follow up activities to identify individuals who have access to other government subsidy programs and/or affordable employer sponsored insurance (ESI);
- Conduct retrospective utilization review to assess medical necessity and appropriateness of the services paid for by the HSN;
- Conduct compliance audits of providers, including analyses of sample claims. Use existing data, including historical UCP data and MassHealth claims data, to determine benchmarks and identify variances to target appropriate auditing activities;
- Analyze HSN paid claims and ERBD claims to identify patterns of unusual or unique billing activities to ensure that claims billed to the HSN are appropriate.

### Implementation Activities

***Routine Monitoring and Reporting***. The Division developed monthly internal management analyses and reports that summarize spending activity and utilization, and support tracking of trends and identification of problem areas. These analyses and reporting activities are reviewed and revised frequently to reflect the changes in eligibility, covered services, demand, funding, and other environmental conditions. These analytics provide the capability to monitor key operational indicators including the following:

- *Eligibility*. Universal access to the Virtual Gateway minimizes the variation and opportunities for provider-originated errors in the eligibility determination process. However, it is still possible for providers to act incorrectly with regard to eligibility status. Frequent standardized reports examine the number of claims denied for eligibility reasons and retroactive eligibility to identify potential issues. Additionally, expanded denial reasons and codes assist the Division staff and providers in analyzing and researching claims denied due to eligibility.
- *Unbundling of services*. Under the HSN08 payment system, hospitals were paid a "bundled" inpatient discharge amount and outpatient visit payment that included all services within a particular stay. Providers thus may have an incentive to "unbundle" the services in their claims; for instance, they

may schedule x-rays and labs on another date of service to maximize payment. Analyses determine baseline activity from the prior three years of data and look for significant changes in provider claims and service provision. Additionally, the HSN incorporated specific logic in the 837 claims adjudication process that identifies claims that should have been bundled across payment periods within the 837 system and/or the prior UB92 claims submission system to ensure appropriate bundling of services. HSN regulations allow payments to be suspended, reduced, or otherwise adjusted if it is determined that a provider's claims include service unbundling, claim up-coding, or other revenue maximization practices.

- *Emergency Room Bad Debt (ERBD)*. Regulations allow providers to submit claims to cover bad debt for emergency room services, but only after certain conditions (regarding collection activity and time delay) are met. Data analyses target potential problems with ERBD claims, such as those claims that are submitted before 180 days from the date of service and/or without the appropriate documentation of collection activities. Additionally, there are circumstances in which providers may receive income for claims in error. Providers are required to report these amounts to the Division, which monitors the reports and makes adjustments to payments made to hospitals. Analysis of free care and ERBD claims provides the HSN with the capability to determine targets for audits and reviews in order to identify this revenue.
- *Claiming volume*. Analyses look for significant discrepancies in providers' claiming volumes to identify potential processing errors and/or demographic changes that could put the HSN at increased financial risk.

***Third-Party Liability***. The Division is working with MassHealth and its partners to develop a third party liability (TPL) review program for the HSN. To date, the Division has entered into an agreement with the UMass Casualty Recovery Unit to recover funds on behalf of the HSN from entities that pay settlements, if it is determined that the case involved HSN payment for medical services related to an accident. Additionally, the Division is working with MassHealth and the Virtual Gateway to modify the Medical Benefit Request (MBR) form to conduct up front screening for other government subsidy coverage where the patient might have eligibility.

***Employer Sponsored Insurance (ESI)***. Beginning on April 1, 2009, individuals who have access to affordable ESI will not be eligible for the HSN unless they enroll in an insurance plan. This policy provides employees with the appropriate incentives to enroll in these plans where available. As part of the access to affordable insurance initiative, the Division, in partnership with MassHealth and the Commonwealth Health Insurance Connector Authority, is implementing a system to identify the availability of ESI. Working with multiple stakeholders, the Division drafted a design that will allow the identification of ESI for potential HSN patients and determine affordability for them. The Division is in contract discussions with a MassHealth vendor to review options for implementation during HSN09.

***Post-Payment Utilization Review***. The Division contracted with University of Massachusetts Medical School (UMMS) to conduct a clinical utilization assessment of the HSN population as the first step in developing an appropriate utilization review model. UMMS will review HSN paid claims to determine service utilization trends and patterns that are unique to the HSN population. From the analysis, UMMS will provide targeted recommendations for the HSN specific utilization review program.

***Provider Compliance Reviews***. In addition to regular reporting and monitoring activity, the Division is beginning the procurement process to engage a contractor to conduct provider compliance reviews of claims and payments. The Division also uses internal staff on an ad hoc basis to conduct desk or other field audits as needed.

These measures, taken in collaboration with MassHealth, will continue to provide significant improvements in the operations and program integrity of the HSN.

## E. Progress on Improvement Plan during HSN08

The table below summarizes progress on the plan that the Division and the Office of Medicaid have undertaken as joint improvement activities.

| Activity | Timeline as of March 15, 2009 |
|---|---|
| **Patient Eligibility** | |
| Coordinated Eligibility Policies | Currently in place and ongoing. |
| Pre-Payment Eligibility | Currently in place and ongoing. |
| Recipient Eligibility Verification System (REVS) | Currently in place and ongoing. |
| Customer Service | Currently in place and ongoing. |
| Provider Outreach and Support | Currently in place and ongoing. |
| **Provider Claims Processing System** | |
| HSN Claims Adjudication | HSN claims adjudication system implemented as of October 1, 2007.<br><br>837I claims submission format is currently in place and the Division is adjudicating claims. 837P and 837D claims submission formats will be in place by December 2009. |
| Pharmacy Claims | A contract with a MassHealth vendor, Affiliated Computer Services (ACS), implemented as of October 1, 2007. |
| **Provider Integrity Systems** | |
| Routine Monitoring and Reporting | Currently in place and ongoing. |
| Third-Party Liability (TPL) | Contract with UMMS Casualty Recovery Unit is in place and the program is in effect. Additional TPL efforts targeted for completion by December 2009. |
| Employer Sponsored Insurance (ESI) | Execute vendor contract or existing contract amendment for March/April 2009. |
| Post-Payment Utilization Review | Contract with UMMS Office of Clinical Affairs is in place. A final report with findings and specific recommendations for an HSN specific utilization review model is targeted for May 2009. |
| Provider Compliance Reviews | Procurement process is underway; anticipate a contract to be in place by March/April 2009. |

# Section IV: Health Safety Net Eligibility Processes

In compliance with Section 15(35)(b)(11) of Chapter 61 of the Acts of 2007, this section reports on the impact and effectiveness of processes used to determine eligibility for reimbursable health services. Specifically, Chapter 61 requires the Division to provide a report "evaluating the processes used to determine eligibility for reimbursable health services, including the Virtual Gateway. The report shall include, but not be limited to, the following:

- an analysis of the effectiveness of these processes in enforcing eligibility requirements for publicly funded health programs and in enrolling uninsured residents into programs of health insurance offered by public and private sources;
- an assessment of the impact of these processes on the level of reimbursable health services by providers; and
- recommendations for ongoing improvements that will enhance the performance of eligibility determination systems and reduce hospital administrative costs."

## A. Introduction to the Eligibility Process

The eligibility process for publicly funded health programs in Massachusetts relies on a collaboration among multiple agencies and several systems. The process begins when a patient fills out an application called a Medical Benefit Request (MBR). The MBR is a uniform application used to determine patient eligibility for MassHealth, Commonwealth Care, and the HSN. Patients may either complete a paper MBR application on their own, or complete an electronic MBR application through the Virtual Gateway with the assistance of a provider or outreach worker.

MassHealth is responsible for processing these applications and determining patient eligibility based on the information submitted. When an application is received, MassHealth's MA-21 system determines the applicant's eligibility. The eligibility system first determines whether an applicant is eligible for MassHealth. If the applicant is not eligible for MassHealth, eligibility for Commonwealth Care is evaluated. If the applicant is not eligible for MassHealth or Commonwealth Care, the MA-21 system evaluates the applicant's eligibility for the HSN.

After a determination is made, several other systems are responsible for communicating patient eligibility to providers and processing claims. The information captured by the application process in the MA-21 system is transferred to the Medicaid Management Information System (MMIS), which is the system that processes MassHealth claims. MMIS then sends patient eligibility information to the Recipient Eligibility Verification System (REVS), the system that providers use to look up MassHealth, Commonwealth Care, and HSN eligibility information. The HSN claims adjudication system also receives eligibility information from both the MA-21 and MMIS. This information is used to ensure that the HSN does not pay for claims for patients who are not HSN-eligible.

MassHealth is currently in the process of implementing NewMMIS, which will replace both MMIS and REVS. NewMMIS will become the claims processing system for MassHealth, and will house the Eligibility Verification System (EVS), which will message patient eligibility to providers.

## B. Effectiveness of Enforcing Eligibility Requirements and Enrolling Residents in Public and Private Insurance

Several mechanisms are used to ensure that the HSN pays only for services provided to eligible patients. One such mechanism is the development of the HSN claims adjudication system. With the exception of ERBD claims and certain other claim types, all HSN claims must be for services provided to patients whose HSN eligibility is found in MA-21 and MMIS. The feed of MA-21 and MMIS eligibility data allows the HSN claims system to reject claims submitted that cannot be matched to an HSN-eligible patient. It also allows the claims system to reject ERBD claims when the patient is found to have eligibility, as claims for insured or HSN-eligible patients do not qualify for ERBD reimbursement. Under the UCP, claims were not adjudicated for payment. In HSN08, using the new claims adjudication system, all non-ERBD HSN claims were matched to an HSN-eligible patient prior to payment, leaving no unmatched paid claims.

Another method of enforcing eligibility requirements is through the MassHealth eligibility redetermination process. During HSN08, the Division worked with MassHealth to initiate the process of redetermining the HSN caseload. According to HSN regulations, an HSN eligibility determination lasts for one year. After this point, a patient's eligibility must be redetermined. Through the redetermination process, households are mailed an Eligibility Review Verification form (ERV) and are required to complete and return the form within 45 days. If a household does not return the form, MassHealth terminates the household's members from the HSN.

In addition to enforcing eligibility requirements, the Division is required by Chapter 58 of the Acts of 2006 to "develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources" (section 55(b)(4)). The Division has undertaken several initiatives to encourage patients to enroll in available affordable insurance plans.

Under the UCP, patients with access to affordable insurance (including those eligible for Commonwealth Care) were able to remain uninsured and eligible for the UCP indefinitely. Under the HSN, patients eligible for Commonwealth Care receive time-limited HSN eligibility in order to allow them time to enroll in a Commonwealth Care plan. As of October 2007, when the HSN replaced the UCP, there were approximately 48,000 individuals eligible for Commonwealth Care who had not yet enrolled in a Commonwealth Care plan. Between October and December of 2007, these patients received letters informing them that their HSN eligibility would end as of a certain date after allowing sufficient time to complete the enrollment process. These letters also provided recipients with information about how to enroll in a plan. These individuals were terminated from the HSN between December 2007 and February 2008. The Division is currently studying the outcomes of this termination process.

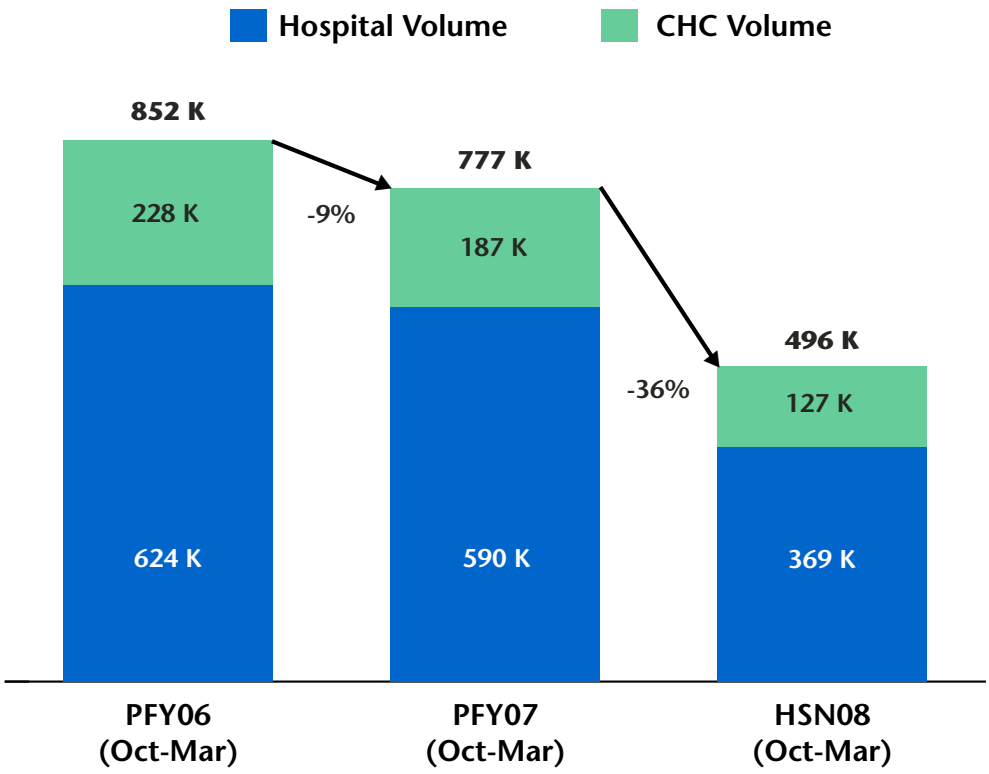
The Health Safety Net Eligible Services regulation requires that beginning on April 1, 2009, individuals with access to affordable insurance from other sources must enroll in an insurance plan. Individuals who have access to affordable insurance and enroll in a plan may retain HSN eligibility, and the HSN will act as a secondary payer to their primary insurance plan for eligible services. Individuals who fail to enroll in an available affordable insurance plan at the next enrollment opportunity will lose their HSN eligibility. The Division is currently working with a vendor to develop a process that will identify patient access to affordable ESI. Additionally, the Division is working with MassHealth to make changes to the MBR application process that will identify access to other types of potentially affordable insurance such as student health insurance, Tricare, and young adult plans. When implemented, these initiatives will encourage enrollment in private insurance plans.

## C. Impact of Eligibility and Enrollment Processes

When the UCP was replaced by the HSN, many changes to the eligibility rules were implemented. Prior to HSN08, any Massachusetts resident with an income under 400 percent of the federal poverty level (FPL) could be determined eligible for the UCP. The UCP would act as a secondary payer to any insurance, including MassHealth and Commonwealth Care, and there were no requirements to enroll in insurance if an affordable plan was available. Today, the HSN provides patients eligible to enroll in Commonwealth Care with time-limited HSN eligibility to allow them time to enroll in a managed care plan. If these patients do not enroll during this 90-day time period, their HSN eligibility is terminated. Also, the HSN does not act as a secondary payer for services provided to patients enrolled in comprehensive MassHealth benefit programs and Commonwealth Care plans, with the exception of eligible dental services provided to patients whose Commonwealth Care plans do not include dental coverage. In HSN08, MassHealth's eligibility systems and the HSN claims system were updated to reflect these policy changes.

The effects of these and other changes related to health care reform are reflected in UCP/HSN visit and discharge volume statistics (see Figure 1). In PFY06 and PFY07 (the first year in which Commonwealth Care was available), total UCP volume from October through March decreased by only nine percent. October through March of HSN08, after the implementation of the new HSN claims and eligibility rules, total HSN volume decreased by an additional 36 percent.

### Figure 1: HSN Total Service Volume Trends



## D. Ongoing Improvements

Several program integrity initiatives described above aim to improve the eligibility systems that the HSN uses and to simplify administrative processes for HSN providers. The development of a process to identify access to affordable ESI and other insurance programs is one such initiative. This project will further improve the eligibility processes used by the HSN by requiring patients to enroll in available affordable insurance plans.

Additionally, the Division is working with MassHealth to ensure a smooth transition from legacy MMIS to NewMMIS when MassHealth implements this change. The Division is reviewing the requirements for EVS, the NewMMIS system that will replace REVS, in order to ensure accurate provider messaging through EVS that reflects HSN policy. The implementation of NewMMIS is intended to result in improvements for providers seeking eligibility information. For example, REVS can have up to a one-day delay in its eligibility information because it is updated daily with information from MMIS. When NewMMIS goes live, EVS will be able to display real-time eligibility information to providers as part of the NewMMIS system. For pharmacy services, the Division and MassHealth are working together to coordinate the Pharmacy Online Payment System (POPS) changes necessary to continue uninterrupted processing of HSN pharmacy claims upon NewMMIS implementation.

In terms of HSN claims adjudication, the Division currently receives a bi-weekly eligibility feed from MassHealth, which is used to enforce HSN eligibility policy through the claims adjudication system. The Division is currently pursuing an initiative with MassHealth to provide a daily eligibility feed that will replace the bi-weekly eligibility feed and further enhance HSN's ability to adjudicate claims in a timely and accurate manner. A daily eligibility feed will improve claims processing by making sure that HSN claims are always adjudicated based on the most recent eligibility information available, and reduce the provider administrative efforts in researching claims denials that resulted from a lag in eligibility information.

Finally, the Division continues to improve enforcement of eligibility rules through the redetermination process. The redetermination process was on hold prior to May 2008, and there is currently an effort in place to reduce the backlog of cases that have had HSN eligibility for more than one year without having gone through the MassHealth redetermination process. MassHealth expects to have this backlog completed by September 2009, at which point the entire HSN caseload will have been redetermined and current in accordance with HSN regulations.

The Division expects that the ongoing improvements noted above will further enhance the outcomes of the HSN's eligibility and adjudication processes, in addition to simplifying administrative processes for HSN providers.

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